EXHIBIT A

Maricopa County Justice Courts, Arizona

Dreamy Draw Justice Court 18380 N 40th St., #130, Phoenix, AZ 85032 602-372-7000

CASE NUMBER CC2022110363SC

Dr Gary L. Wagoner is the Designated Representative for
patient Caitlin Walls.
702 E. Bell Rd. #112
Phoenix, AZ. 85022 (602) 338-6251
drgarydcbh@yahoo.com
Plaintiff(s) Name / Address / Email / Phone

Pinnacle West Capital Corporation
400 North 5th Street
Phoenix, AZ 85004
(602) 371-7171
email is not available
Defendant(s) Name / Address / Email / Phone

SMALL CLAIMS SUMMONS ☐ **Replacement** ARSCP 5(b)

The Statutory Agent / Corporate Officer to be served is: CT Corporation Systems
Service of Legal Process for Pinnacle West Capital Corp.
3800 N Central Avenue, Suite 460
Phoenix, AZ. 85012
(800) 624-0909
Name / Address / Email / Phone

Notice: A separate Summons will be issued for each named defendant on the complaint.

TO THE ABOVE-NAMED DEFENDANT: You are directed to answer this complaint within **20 calendar days** by filing a written Answer in the court named above. If you do not answer or defend, you run the risk of having a judgment entered against you for the amount of plaintiff's claim, plus court costs. A filing fee must be paid at the time your answer is filed. If you cannot afford to pay the required fee, you may request that the Court either waive or defer the fee.

REQUESTING AN INTERPRETER OR SPECIAL ACCOMMODATIONS: The court should be notified of requests for an interpreter or special accommodations at least *15 calendar days* before a court date.

Date: 7-7-22 ca
Clerk

Please inform court staff if interpreter services are required.
☐ Yes, I need interpreter services. Language: _____

SC 8150-300.2 R: 1/1/20

READ THIS NOTICE CAREFULLY

Notice to Plaintiff and Defendant: A small claims lawsuit has been filed in justice court.

- A small claims lawsuit is an informal way to resolve civil disputes that are $3,500 or less.
- Parties in a lawsuit are called "plaintiff" and "defendant." Plaintiffs start a lawsuit by filing a complaint against defendants.
- PLAINTIFF: A lawsuit against the defendant cannot proceed without proper service as described in the Arizona Rules of Small Claims Procedure. When you file your Complaint, the court will provide you with a Summons and a copy of this notice that you must serve on each defendant along with the Complaint. You must file proof of service within 45 calendar days or your case may be dismissed. If proof of service is not timely filed or your case is not concluded within 65 days of the date the defendant was served, the court may dismiss your case unless it finds a good reason not to.
- DEFENDANT: You must file a written answer and mail a copy to the plaintiff. Otherwise, judgment may be entered against you. If you have a claim against the plaintiff, even if it is based on a different event than described in the complaint, you may file a counterclaim and must mail a copy to the plaintiff.
- BOTH PARTIES: You must provide supporting evidence for your claims and defenses and must appear at all scheduled hearings or alternative dispute resolution conferences.
- A Justice of the Peace or a Hearing Officer with specialized training will conduct the hearing. You should be prepared to clearly present your evidence. Although you may be permitted to appear telephonically if needed, you must submit all evidence to the court before the hearing. If you fail to appear at a hearing, the court may enter a judgment against you. To ensure that you receive these notices, you must keep the court informed, in writing, of your current address and telephone number until the lawsuit is over.
- You must follow the Arizona Revised Statutes and Arizona Rules of Small Claims Procedure that apply in your lawsuit. The statutes and rules are available in many public libraries and at the courthouse. The statutes are also online at the Arizona State Legislature webpage, and the rules are online at the Arizona Judicial Branch Court Rules webpage.
- You must properly complete court papers and file them when they are due. Blank forms are on the Arizona Judicial Branch website and available from any justice court.
- Some filings require a filing fee. Parties can request a fee waiver or deferral from the court but must still file documents on time.
- Court staff cannot give legal advice but can provide information about jurisdiction, venue, pleadings, and procedures for the small claims division of the justice court.
- **There are no attorneys in a small claims lawsuit unless the parties agree in writing**. Individuals usually represent themselves. One spouse may represent both spouses. A full-time corporate officer or authorized employee may represent a corporation; an active general partner or an authorized full-time employee may represent a partnership; an active member or an authorized full-time employee may represent an association; and any other organization may be represented by one of its active members or authorized full-time employees.
- **Parties cannot appeal a small claims judgment**. Parties may request to transfer the lawsuit from small claims to the regular Civil Division of the justice court. A transfer will allow:
  - Attorney representation without written agreement;
  - Counterclaims for more than $3,500;
  - Motions that are not permitted in small claims lawsuits;
  - A jury trial; and
  - An appeal.

EXHIBIT B

Maricopa County Justice Courts, Arizona

Dreamy Draw Justice Court 18380 N 40th St., #130, Phoenix, AZ 85032 602-372-7000

CASE NUMBER: CC2022160363 SC

Dr Gary L. Wagoner is the Designated Representative for
patient Caitlin Walls.
702 E. Bell Rd. #112
Phoenix, AZ. 85022 (602) 338-6251
drgarydcbh@yahoo.com
Plaintiff(s) Name / Address / Email / Phone

Pinnacle West Capital Corporation
400 North 5th Street
Phoenix, AZ 85004
(602) 371-7171
email is not available
Defendant(s) Name / Address / Email / Phone

2nd Named Defendant: N-A

3rd Named Defendant: N-A

SMALL CLAIMS COMPLAINT

ARSCP 4

WARNING: THERE ARE NO APPEALS IN SMALL CLAIMS CASES. You do not have the right to appeal the decision of the Hearing Officer or the Justice of the Peace in the Small Claims Division of this court. If you wish to preserve your right to appeal, you may have your case transferred to the Civil Division of this court. If you request such transfer, allow at least 10 business days prior to the day of the scheduled hearing. ARS 22-504, ARSCP 11(a)

This court has venue over this matter because:

☐ Defendant resides in this precinct.

☒ The debt, transaction or incident that resulted in this claim occurred in this precinct at the following location (ARS 22-202):
Dr. Gary L. Wagoner 702 E. Bell Rd. Suite 103 Phoenix, AZ. 85022

$ 3,500.00 is the total amount owed me by defendant because (please attach additional page(s) if more room is needed):

1. This is a complaint of breach of contract and unjust enrichment due to an illegal denial of a medical claim committed by Pinnacle West Capital Corp which is a violation of A.R.S. Title 20 § 20-103(A). See pages 2-5 of Supporting Documents.
2. Violation of A.R.S. Title 20 § 3102 failure to make timely payment of a medical claim. See page 2-5 of Supporting Docs.
3. Violation of A.R.S.Title 20 § 2533(d) failure to disclose and release requested appeal information, instructions and appeal forms. See page 2-5 of the Supporting Documents.
4. Violation of A.R.S. Title 20 § 2532(G) failure to release requested Plan information regarding utilization review agent. See pages 2-5 of the Supporting Documents.
5. Violation of A.R.S. Title 20 § 2532(D) use of an un-certified medical review agent. See pages 2-5 of Supporting Docs.

To the best of my knowledge and belief:

Date: 7-6-2022 Dr. Gary L. Wagoner
Plaintiff (signature)

22 JUL -7 AM 9:51
JUSTICE COURT
FILED

Please inform court staff if interpreter services are required.
☐ Yes, I need interpreter services. Language: _____

NOTICE: If you are representing a partnership, association or any other organization, provide the court with a notice stating your position and authority to represent this action.

SC 8150-300.01 R: 1/1/20

Dr. Gary L. Wagoner
Designated Representative for Patient Caitlin Walls
16356 N. Thompson Peak Pkwy. #1089
Scottsdale, AZ. 85260
(480) 343-0585
fax (480) 687-5989

THE FOLLOWING ARE FACTS

SUPPORTING CASE DOCUMENTATION SHOWING BREACH OF CONTRACT AND UNJUST ENRICHMENT BY DEFENDANT PINNACLE WEST CORPORATION

July 5, 2022

Service of Legal Process for Pinnacle West Capital Corporation
CT Corporation Systems
3800 N Central Avenue
Suite 460
Phoenix, AZ 85012

Defendant / Employer: Pinnacle West Corporate Headquarters
400 North 5th Street
Phoenix, AZ 85004

Re: Caitlin Walls
DOB: 6/04/1985
Member ID# U0989213001
Group #: 3341058
Date of Service: 12-11-18
Amount: $2,750.00 (plus fees and allowed interest)
Amount Paid: $0
Past Due Balance: $3,500.00
Claim # 136814971, 1836032367, 4191834890829, 4191914991478, ND1046 and U09892130

Pinnacle West Capital Corporation Past Due Balance: $2,750.00, plus allowed interest, court costs and process service fees. This comes to a total of **$3,500.00**

A total of 9 demand for payment letters and telephone conversations have been submitted to Pinnacle West Capital Corporation. Payment has not yet been tendered despite promises to pay this claim by Pinnacle West Capital Corporation.

Medical services provided by:
Dr. Gary L. Wagoner / Starboard Attitude Trust
16356 N. Thompson Peak Pkwy, # 1089
Scottsdale, AZ 85260
(602) 338-9251

Medical services were performed at:
Valley Wellness Center
702 E. Bell Rd. #103
Phoenix, AZ 85022
(602) 603-2282

Dear Honorable Frank Conti. Jr,

Plaintiff Dr. Gary L. Wagoner (Wagoner) is the Designated Representative for patient Caitlin Walls. Defendant Pinnacle West Corporate (PWC) has "unjustly denied" payment and "unjustly enriched itself" at the expense of the insured member, despite the services being covered benefits of the Plan. Wagoner requested from PWC in 9 separate demand for payment letters the immediate payment of $2,750.00 for medical services. Payment has not yet been tendered, hence this law suit.

In order to assess the accuracy of PWC's claim denials Wagoner has requested from PWC all Plan documents and internal claim adjudication methodologies regarding which PWC claim denial method(s) were used to calculated the claim and what portion of the PWC Out Of Network fee schedule was utilized. The insured member has also submitted an Assignment of Benefits and a Power of Attorney contract to allow the Designated Representative all rights under the policy, including appeal rights, direct payment collection rights, disclosure access and litigation, have been transferred to the provider Dr. Gary Wagoner.

As of July 5, 2022 PWC has FAILED released any of the requested information.

By failing to provide the requested information noted above, PWC has "unjustly denied" payment and "unjustly enriched itself" at the expense of the insured member, despite the services being covered benefits of the Plan.

The repeated delays by PWC in sending the past due payment of $2,925.00 will no longer be tolerated and Wagoner will take action. The collection of interest on the Settlement Amount (10% per annum, as per A.R.S. § 44-1201A) Arizona HB 2138 – the "Health Care Provider Timely Payment and Grievance Law" – allows a provider to charge and collect interest payments against PWC on clean claims that have not been paid in full in a timely fashion.

Arizona "Health Care Provider Timely Payment and Grievance Law" HB 2138 allows for the medical provider to charge and collect interest payments against an insurance company on clean claims that have not been paid in full.

Pursuant to Arizona Department of Insurance (A.R.S. § 20-464) Wagoner has been appointed by the insured member Caitlin Walls as her Designated Representative for this collection action of a past due medical payment. The insured member has also signed an Assignment of Benefits and a Power of Attorney contract to allow the Designated Representative all rights under PWC's medical benefits policy for its employees, including appeal rights, direct payment collection rights, disclosure access and litigation, have been transferred to the provider Dr. Gary Wagoner.

Wagoner and insured member is seeking payment in full for the past due balance of $2,750.00, plus allowed interest, court costs and process service fee. **This come to a total of $3,500.00**

Your Honor, PWC has committed a breach of contract with a plethora of violations against A.R.S. Title 20 with the illegal adjudication and denial of this Out Of Network medical claim. Page 113 of the attached Summary Plan Description (SPD) states that PWC is *"solely responsible for the timely payment of Benefits"* and *"Pinnacle West...have the sole and exclusive discretion to interpret Benefits under the Plan; interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and make factual determinations related to the Plan and its Benefits."*

PWC is the *"Plan Fiduciary, Plan Sponsor, Plan Administrator and Benefits Administration Committee"* as shown on page 110 and 114 of the attached SPD.

The PWC medical insurance benefits Plan meets the requirements of A.R.S. Title 20 § 20-103 (A) *For the purposes of this title, except as otherwise provided, "insurance" is a contract by which one undertakes to indemnify another or to pay a specified amount on determinable contingencies. A.R.S. Title 20 § 20-106 (B)(7) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance."*

Pursuant to A.R.S. Title 20 regulations requires PWC to unambiguously outline coverage terms and release how benefits are calculated so that policy holders are aware of the benefits available specifically instructing group health plans to release the schedule of fees even if proprietary.

PWC's failure to provide this requested information from 9 separate requests for said information is a direct violation of Arizona law. PWC has failed to specifically disclose the requested Plan documents, allowed amounts, Out Of Network claim submission time line, Out Of Network claim submission address (employer OR Cigna), description of any

additional material or information necessary to perfect the claim, and an explanation of why such material or information is necessary, and the justification for claim denial based on "medical necessity".

Wagoner apologies in advance for the plethora of complex information contained herein, *which should be completely unnecessary,* however PWC has brought it upon themselves based upon their own utter incompetence in breaching the Plan contract and blatant disregard for the rules and procedures set forth under Arizona Revised Statutes Title 20.

Medical services for this claim are broken down into one (1) specific code called a CPT code. The code has specific and unique descriptions of its described service. The CPT service code comes from the Current Procedural Terminology from the American Medical Association and has been authorized for use by the federal government CMS Centers for Medicare and Medicaid.

Misrepresenting benefits in writing using an insurance company letter is a serious violation of Arizona state insurance law under Title 20, hence this lawsuit. Also, pursuant to A.R.S. Title 20 the SPD must include a list of CPT code medical services that are NOT covered by PWC insurance Plan. The SPD does NOT have this required list, hence this lawsuit.

- Your honor, the following are specific A.R.S. Title 20 violations committed by PWC:

1. A.R.S. Title 20, Section 3102 is amended to read, "Timely payment of health care providers' claims; contractual grievances," states: (A) "*..the health care insurer shall pay the approved portion of any clean claim within thirty days after the claim is adjudicated. If the claim is not paid within the thirty day period or within the time period specified in the contract, the health care insurer shall pay interest on the claim at a rate that is equal to the legal rate. (C) "A health care insurer shall not delay the payment of clean claims to a contracted or non-contracted provider...".* PWC has failed to comply with this statute.

2. A.R.S. Title 20, Section 2533 is amended to read, *"Denial; levels of review; disclosure; additional time after service by mail; review process,"* stipulates in paragraph (d) that the following disclosure be made regarding benefits and reimbursement appeal rights: *"At the time of issuing a denial, the health care insurer shall notify the member of the right to appeal under this article. A health care insurer that issues an adverse benefits determination document shall satisfy this obligation by prominently displaying in the document a statement about the right to appeal. A health care insurer that does not issue an adverse benefits determination document shall satisfy this obligation through some other reasonable means to assure that the member is apprised of the right to appeal at the time of a denial. A reasonable means that includes giving the member's treating provider a form statement about the right to appeal shall require the treating provider to notify the member of the member's right to appeal."* PWC has failed to comply with this statute.

3. A.R.S. Title 20, Section 2532 is amended to read, "Utilization review standards and criteria; requirements." This statute requires utilization review agents to maintain minimum standards for adverse benefit determination notification. Paragraph G of this statute states the following regarding disclosure: *"On written request, the utilization review agent shall provide copies to any member or the member's treating provider of: 1. Those portions of the utilization review agent's utilization review plan that are relevant to the request for a covered service or claim for a covered service. 2. The protocols or guidelines that were used if the standards and criteria adopted are based on protocols or guidelines developed by an American medical specialty board."* PWC has failed to comply with this statute.

4. A.R.S. Title 20, Section 2532 (D) "*A health care insurer who utilizes the services of an outside utilization review agent is responsible for the utilization review agent's acts that are within the scope of the written and filed utilization review plan, including the administration of all patient claims processed by the utilization review agent on behalf of the health care insurer."* Cheryl Dopke DO is the Cigna employee that adjudicated and denied this claim is NOT certified in Nerve Conduction Velocity medical service operations. PWC has failed to comply with this statute.

The SPD clearly shows the provided medical service as being a covered service and not explicitly excluded from the Plan. The SPD must contain a number of items of particular interest to medical providers including assignment provisions, benefit information, medical necessity, pre-existing condition and usual, reasonable and customary charge exclusions / limitations, procedure for submitting claims and appeals and name, address and business telephone number of the Plan administration.

PWC is "unjustly denying" payment and "unjustly enriching itself" at the expense of the insured member for the covered service in this claim, which is a violation of A.R.S. Title 20, hence this law suit.

Common law assumes that inherent in every contract is the implied duty of good faith and fair dealings. Certain common law responsibilities relate to the construction of managed care agreements (i.e., vague and ambiguous provisions are interpreted to the benefit of the non-drafter policyholder and healthcare provider and against the insurer – see Matter of United Community Ins. Co. v. Mucatel, 69 NY2d 777, 779, aff'd at 127 Misc.2d 1045; Hartol Products Corp. v. Prudential Ins. Co., 290 NY 44, 49).

It is our opinion that bad faith law is applicable to any insurer's conduct that is so reckless and severe and creates severe civil and criminal sanctions against the insurer.

I Timeline of events:

1. **On 12-13-2018:** The initial HCFA 1500 medical claim form was submitted to Cigna for payment of this medical claim for benefits.
2. **On 12-15-2018:** Wagoner received a denial letter from PWC / Cigna denying the medical claim for unjustified *"experimental"* reasons without the required method of correction, and also for a diagnosis code that is *"not valid"*, also without justification or the required method of correction.
3. **On 12-19-2018:** Wagoner yet again received a denial letter from PWC / Cigna denying the medical claim for unjustified *"experimental"* reasons without the required method of correction, , and also for a diagnosis code that is *"not valid"*, also without justification or the required method of correction.
4. **On 1-9-2019:** Wagoner yet again received a denial letter from PWC / Cigna denying the medical claim for unjustified *"experimental"* reasons without the required method of correction,, and also for a diagnosis code that is *"not valid"*, also without justification or the required method of correction.
5. **On 1-23-19:** Wagoner was on a telephone call with PWC / Cigna with Cigna call reference # 3921. The claim is re-processed for payment. PWC / Cigna states that the submitted diagnosis codes and CPT code 95910 are **covered services** by the Plan. The PWC / ***Cigna Medical Coverage Policy- Therapy Services Electrodiagnostic Testing (EMG/NCV)*** *Effective Date: 11/15/2018 Next Review Date: 8/15/2019* cover the diagnosis and CPT codes that are used in this claim. The submitted codes conform to this document. There is no justified reason for claim denial based on this document.
6. **On 6-1-2019:** Wagoner yet again received a denial letter from PWC / Cigna denying the medical claim for unjustified *"experimental"* reasons without the required method of correction,, and also for a diagnosis code that is *"not valid"*, also without justification or the required method of correction.
7. **On 6-4-2019:** Wagoner yet again received a denial letter from PWC / Cigna denying the medical claim for unjustified *"experimental"* reasons without the required method of correction,, and also for a diagnosis code that is *"not valid"*, also without justification or the required method of correction.
8. **On 7-13-2019:** Wagoner yet again received a denial letter from PWC / Cigna denying the medical claim for unjustified *"experimental"* reasons without the required method of correction,, and also for a diagnosis code that is *"not valid"*, also without justification or the required method of correction.

9. **ERISA preemption does not exist because of this letter from PWC / Cigna dated 7-16-2019:** Wagoner received a denial letter from PWC / Cigna with new instructions to submitted a "corrected claim" including specific instructions to change the previously submitted diagnosis code. Wagoner complied and submitted a "corrected claim" as per the instructions.

10. **On 7-16-2019:** Wagoner yet again received a denial letter from PWC / Cigna denying the medical claim for unjustified *"experimental"* reasons without the required method of correction,, and also for a diagnosis code that is *"not valid"*, also without justification or the required method of correction. The letter was signed by Cigna medical director Cheryl Dopke, DO.

11. **On 7-29-19:** Wagoner faxed and mailed a request letter to PWC / Cigna for a 2nd level Peer-to-Peer meeting with a licensed chiropractor in the state of Arizona that is certified to operate a Nerve Conduction Velocity machine regarding this medical claim.

12. **On 8-26-2019:** Wagoner faxed and mailed a demand for payment letter to PWC / Cigna.

13. **ERISA preemption does not exist because of this conversation with PWC / Cigna dated 8-28-19:** Wagoner had a telephone conversation with Carrie Lewis from the Cigna executive offices located in Phoenix with number (800) 446-6633 and (770) 779-6990 Carrie Lewis at CIGNA executive offices in Phoenix. Carrie Lewis instructed Wagoner to keep sending appeals and demand for payment letters to fax (860) 683-9167 and to email the same to carrie.lewis3@cigna.com Carrie Lewis also said to *"Keep sending faxes and all payment demand letters and appeals to the Cigna CEO office and let them know about the unpaid claims."*

14. **On 8-28-19:** Wagoner received a letter from PWC / Cigna from Carrie Lewis. She stated that she is investigating my medical claim and she wants me to keep in touch with her.

15. **On 9-3-19:** Wagoner received a telephone message call from PWC / Cigna employee Dr. Lamay. Lamay stated that he was told to call me to requested a Peer-to-Peer conversation with me regarding patient Caitlin Walls nerve conduction velocity test. Lamay left his telephone number with Wagoner for a return call. Wagoner called him back approximately one hour later and commenced the Peer-to-Peer conversation. Wagoner was asked general clinical questions that justified the medical necessity for the nerve conduction velocity test, despite the fact that on the patients SPD there is no requirement for a pre-authorization for this specific test. Lamay then stated that he would submit this information to Cigna. Wagoner explained to Lamay that this Peer-to-Peer conversation was due to an A.R.S. Title 20 violation complaint that the patient has submitted to PWC / Cigna recently. Lamay said that this issue "was above his pay grade". Wagoner thanked Lamay for

the Peer-to-Peer. Wagoner has not received any written requests for this Peer-to-Peer or any clinical information requested by PWC / Cigna.

16. **On 9-4-19:** Wagoner received yet again another telephone call from Dr. Lamay to verbally request the nerve conduction velocity medical report. Lamay gave Wagoner a fax number (866) 213-3207 and instructed Wagoner to attention the report to someone named Denise, and to include the name of the nerve conduction velocity unit and my board certification to operate the nerve conduction velocity unit. Once again, Wagoner did not received any written requests for this clinical information by WPC / CIGNA. Wagoner faxed, email, and sent by U.S. certify mail the nerve conduction velocity unit information directly to Cigna CEO David Cordani. Once again, Wagoner has not received any written requests for this clinical information by WPC / CIGNA. It could be interpreted by an investigator that this is an attempt to deflect attention from the original complaint filed by the insured member to turn this into a medical necessity issue in order to inject a secondary denial of payment of an eligible expense for a plan benefit described in the members SPD.

17. **On 10-13-2019** Wagoner faxed and mailed yet again another demand for payment letter to PWC / Cigna.

18. **On 12-5-2019:** Wagoner received a letter from PWC / Cigna and American Specialty Health that denied the medical claim because Wagoner is an Out Of Network medical provider. However, the Plan and the SPD clearly show that the insured member has Out Of Network medical benefits and Wagoner's services are eligible for payment.

19. **On 6-14-2021** Wagoner faxed and mailed yet again another demand for payment letter to PWC / Cigna.

20. **On 7-13-2021** Wagoner faxed and mailed yet again another demand for payment letter to PWC / Cigna.

21. **ERISA preemption does not exist because of this conversation with PWC / Cigna dated on 12-7-2021** Wagoner had a telephone call with PWC / Cigna with a call reference # 9687 with Cigna employee Brad Grimes from the Executive Offices Advocacy Team. Grimes said that PWC / Cigna has *"purged their system of call records regarding calls to Wagoner from the CEO's office, attorney Susan Schwartz office and two calls from a Peer-to-Peer supervisor."* Grimes said a Level 2 appeal meeting to talk about paying the medical claim with PWC / Cigna is tomorrow on 12-8-2021 and Wagoner will be on the call with PWC / Cigna. Destroying medical records is a violation of HIPAA and A.R.S. Title 20.

22. **On 12-8-2021:** Wagoner sent the following letter to the Level 2 Appeal Panel at PWC / Cigna following a scheduled telephone conversation: *"Thank you for calling me this morning. As I have reviewed all available records from Cigna*

regarding the adjudication of this claim it seems that Cigna has never requested any other medical records besides the NCV/EMG data report. That being said, per your request this morning on the conference call I have faxed to you the attached SOAP notes from Caitlin Walls pain management provider along with my office SOAP notes. Caitlin was referred to my office for chiropractic care by her pain management provider regarding her lumbar spine and her associated radicular symptoms, hence the NCV study. Also, on January 23, 2019 with a call reference # 3921 I spoke to your Cigna customer service representative who informed me that CPT 95910 is a Covered Health Service under this patients Plan. Cigna has denied payment of this procedure based on your opinion that the procedure is "experimental, investigational or unproven". I have attached (a copy of the Exclusions and Experimental clauses from the insured members Summary Plan Description. There is no mention that CPT 95910 is excluded. Cigna is arbitrarily denying CPT code 95910. On 9-3-19 I received a telephone message call from a Cigna employee named Dr. Lamay. He stated that he was instructed to call me and establish a "a peer-to-peer" conversation with me regarding patient Caitlin Walls NCV test. He left his telephone number with me for a return call. I called him back approximately one hour later and commenced the peer-to-peer. I was asked general clinical questions that justified the medical necessity for the NCV test, despite the fact that on the patients Summary Plan Description (SPD) there is no requirement for pre-authorization for this specific NCV test. Dr. Lamay then stated that he would submit our conversation information to CIGNA. I explained to him that this peer-to-peer conversation was due to an ERISA violation complaint that the insured member has submitted to CIGNA recently. He said that this issue "was above his pay grade". We thanked each other for our peer-to-peer encounter and said good bye. As of todays date 12-8-2021 I have not yet received any written requests for this peer-to-peer or any medical records information requested by CIGNA. Further, on 9-4-19 I received a second call from A Cigna employee named Dr. Lamay. He verbally asked me to fax the NCV report to him. He gave me a fax number (866) 213-3207 and instructed me to attention the report to someone named Denise, and to include the name of the NCV unit and my board certification to operate the NCV unit. Again, I have not received any written requests for my operators license or the NCV equipment specifications by Cigna. On 12-7-2021 I spoke with a Cigna call ref # 9687 Brad Grimes at your Executive Offices Advocacy Team. He said that Cigna has purged their system of call records regarding calls to me from the CEO office, Susan Schwartz office and two calls from a peer to peer supervisor. This is a HIPAA violation..."

23. **On 2-3-2022:** Wagoner received yet again another PWC / Cigna appeal denial letter with a plethora of Title 20 violations. The letter failes to acknowledge the previously submitted "corrected claim" with a new diagnosis code that PWC / Cigna instructed Wagoner to submit. The new diagnosis is Gullian-Barre syndrome and it conforms to the PWC / Cigna clinical guidelines for nerve conduction velocity testing. See the attached "corrected claim" HCFA 1500 form.

This is an **Out Of Network** clean claim and pursuant to A.R.S. Title 20 this claim must be adjudicated as an **Out Of Network** claim because there is **no contractual agreement** between the provider and the insurance company.

Based on the above-cited facts, PWC has "unjustly denied" payment and "unjustly enriched itself" at the expense of the insured member, despite the services being covered benefits of the Plan.

Wagoner and insured member is seeking payment in full for the past due balance of $2,750.00, plus allowed interest, court costs and process service fee. **This come to a total of $3,500.00**

Sincerely,

Dr. Gary L. Wagoner

Dr. Gary L. Wagoner
Designated Representative
Certified Nerve Conduction Velocity Operator
Certified Manipulation Under Anesthesia

Valley Wellness Center PLLC Integrated Pain Specialist
702 East Bell Road Suite 103 Phoenix, AZ 85022
Office:602-603-2278 Fax: 602-910-3397

Patient Demographic Information

As of 11/09/2018, in ElationHealth

Patient Name	Sex	Birthdate	SSN
Caitlin Walls	F	06/04/1985	

Address

5609 W. Desperado Way
Phoenix, AZ 85083

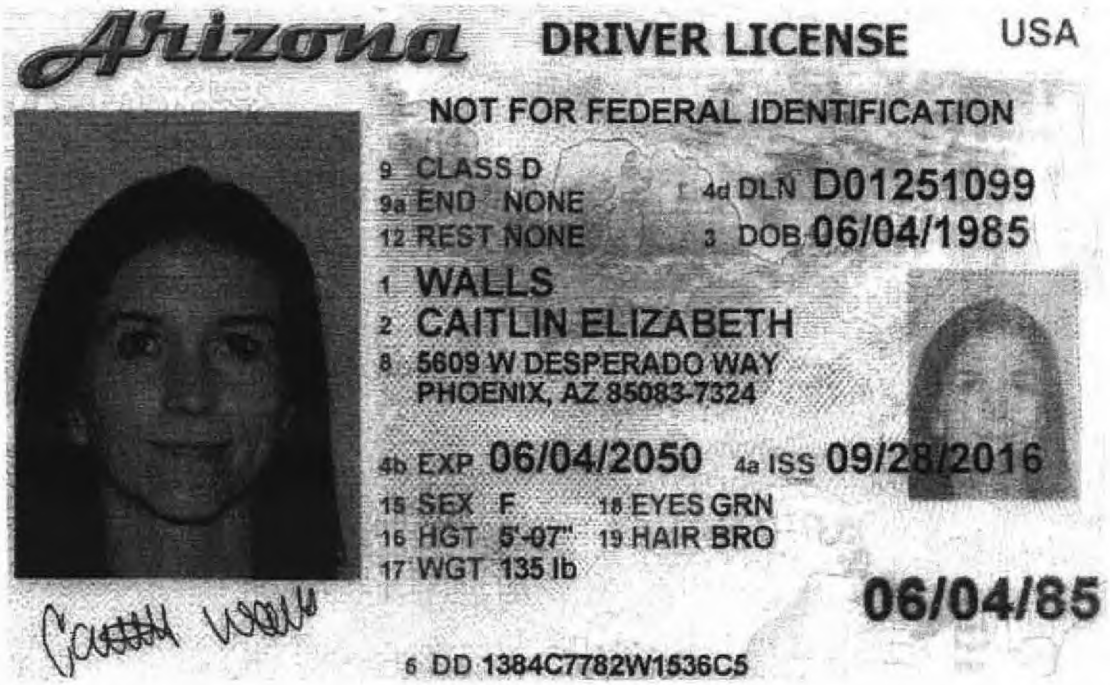
Contact Details

Cell Phone: 623-203-0547
Phone 2:
Email: jaeandmommy@gmail.com

Primary Provider in Practice	Preferred Language	Preferred Method of Contact
Jennifer Austin Slack, NP-C		

Primary Insurance

Plan Name: CIGNA PPO
Group No.: 3341058
Member No.: U0989213001


Arizona
DRIVER LICENSE
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NOT FOR FEDERAL IDENTIFICATION
9 CLASS D
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4d DLN D01251099
3 DOB 06/04/1985
1 WALLS
2 CAITLIN ELIZABETH
8 5609 W DESPERADO WAY
PHOENIX, AZ 85083-7324
4b EXP 06/04/2050
4a ISS 09/28/2016
15 SEX F
18 EYES GRN
16 HGT 5'-07"
19 HAIR BRO
17 WGT 135 lb
06/04/85
6 DD 1384C7782W1536C5

myCigna.com

aps

Administered By Cigna Health and Life Insurance Co.

Coverage Effective Date: 01/01/2018

Group: 3341058

ID: U09892130 01

Name: Caitlin Walls

Consumer Plan

MultiPlan

Network Savings Program

Open Access Plus

No Referral Required	
PCP Visit	**10%**
Specialist	**10%**
Hospital ER	**10%**
Urgent Care	**10%**
Network Coinsurance:	
In	**90%/10%**
Out	**50%/50%**

Med/Rx Deductible Applies

Cigna, ATTN: Complex Claim Unit (CCU)
7555 Goodwin Road
Chattanooga, TN 37421

December 19, 2018

GARY L WAGONER DC
1089 16356 N THOMPSON PEAK
SCOTTSDALE, AZ 85260-2103

RE: CAITLIN WALLS
Customer ID #: U09892130
Authorization Code: Not Applicable
Patient Account #: 1836032367
Service Provider: GARY L WAGONER DC
Health Care Provider Tax ID#: 27-6938695

Claim Reference	Date(s) of Service	Claim Total Charge	Charges Not Paid By Your Health Plan
4191834890829	12/11/2018 – 12/11/2018	$2,750.00	$2,750.00

9220905333301

Health Care Provider: This is a copy of a letter sent to the patient indicated below. If you would like to speak to a physician reviewer about this decision, please call us at 1.800.558.7390 Option #3. However, please be aware that the physician reviewer will only have available the limited information supplied on the claim. Therefore, your two best options to have this decision reconsidered may be to resubmit the claim using a covered service code or to appeal this decision as directed in this letter.

Cigna Health Management, Inc., on behalf of PINNACLE WEST CAPITAL CORPORATION

Dear CAITLIN WALLS,

We received claim 4191834890829 for services received between 12/11/2018 – 12/11/2018 from GARY L WAGONER DC. You are receiving this letter because, as noted on your Explanation of Benefits, there is a service we cannot cover under your benefit plan because it is considered experimental, investigational or unproven for the diagnosis. The dollar amount of the service not covered, the description, and reason why the service is not covered is noted below. Please see your Explanation of Benefits statement for information regarding coverage for other services provided.

Note: We sent this letter to meet federal and state requirements.

Details about this service

PXDX-01

Provider Explanation of Medical Benefits Report

Cigna

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
276938695 0003	STARBOARD ATTITUDE TRUST	12/15/2018		1

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
	Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.														
	PATIENT NAME: CAITLIN WALLS				PATIENT#: 1836032367				OPERATION LOCATION/GROUP# 56331-9-3341058 RECEIVE DATE: 12/13/2018 PROCESS DATE: 12/15						
	PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER				PROVIDER NETWORK STATUS: OUT OF NETWORK										
	SUBSCRIBER NAME: CAITLIN WALLS				SUBSCRIBER#: U09892130				REF#: 4191834890829						
1	12112018	95910		2750.00								0.00	0.00	0.00	A0
	TOTAL			2750.00										0.00	

BALANCE..... $2,750.00

** NOTES ON BENEFIT DETERMINATION:
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

SYS-BS8

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) THIS SERVICE IS NOT COVERED BECAUSE IT IS CONSIDERED EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN FOR ALL INDICATIONS.

007222

Provider Explanation of Medical Benefits Report

Cigna.

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
276938695 0003	STARBOARD ATTITUDE TRUST	06/01/2019		1

Line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
	Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.														
	PATIENT NAME: CAITLIN WALLS PATIENT#: ND1046 OPERATION LOCATION/GROUP# 56331-9-3341058 RECEIVE DATE: 05/29/2019 PROCESS DATE: 06/01 PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER PROVIDER NETWORK STATUS: OUT OF NETWORK SUBSCRIBER NAME: CAITLIN WALLS SUBSCRIBER#: U09892130 REF#: 4191914991478														
1	12112018	95910		2750.00		2750.00						0.00	0.00	0.00	A0
	TOTAL			2750.00		2750.00								0.00	

BALANCE..... $2,750.00

** NOTES ON BENEFIT DETERMINATION:
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

MN2-AGN

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) THIS SERVICE IS NOT COVERED BECAUSE IT IS CONSIDERED EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN FOR ALL INDICATIONS.

Cigna Health and Life Insurance Company
PHOENIX CLAIM OFFICE
P.O. BOX 182223
CHATTANOOGA, TN 37422-7223

Cigna Health and Life Insurance Company
AS AGENT FOR:

APS

Provider Number:
276938695 0003

Date through which claims were processed:
JUNE 1, 2019

Remittance Tracking Number:

STARBOARD ATTITUDE TRUST
1089
16356 N THOMPSON PEAK PKWY APT 1089
SCOTTSDALE AZ 85260-2103

How to Contact Us
Mail to the return address in upper left corner of this page
http://www.cigna.com
Phone: (800) 477-4277

Provider Explanation of Medical Benefits

Understanding this Benefits Statement

This page provides a summary of the payments made this period.

The accompanying pages give more detail on the claims we processed for this period. Please review both the front and back of each page to see how the benefit amounts shown in the Explanation of Medical Benefits Report were determined.

In the event a claim is denied.....

Rights of Review and Appeal - For Physician or Health Care Provider

If you have questions or disagree with the payment identified on this Explanation of Medical Benefits statement, you may ask to have it reviewed.

If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

- Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.
- If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan).
- Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.
- Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- You are entitled to receive free upon request access to , and copies of, all documents, records and other information relevant to your claim for benefits.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Provider Summary

No Payment was made with this statement

The charges submitted were negated or offset by the deductibles, coinsurance, etc., or the patient(s) may be incurring liability for payment. See the following provider detail page for an explanation of how the benefits were determined.

Cigna, ATTN: Complex Claim Unit (CCU)
7555 Goodwin Road
Chattanooga, TN 37421

Cigna

June 4, 2019

CAITLIN WALLS
5609 W DESPERADO WAY
PHOENIX, AZ 85083-0000

RE: CAITLIN WALLS
Customer ID #: U09892130
Authorization Code: Not Applicable
Patient Account #: ND1046
Service Provider: GARY L WAGONER DC
Group Account #: 3341058

Claim Reference	Date(s) of Service	Claim Total Charge	Charges Not Paid By Your Health Plan
4191914991478	12/11/2018 – 12/11/2018	$2,750.00	$2,750.00

Cigna Health Management, Inc., on behalf of PINNACLE WEST CAPITAL CORPORATION

Dear CAITLIN WALLS,

We received claim 4191914991478 for services received between 12/11/2018 – 12/11/2018 from GARY L WAGONER DC. You are receiving this letter because, as noted on your Explanation of Benefits, there is a service we cannot cover under your benefit plan because it is considered experimental, investigational or unproven for the diagnosis. The dollar amount of the service not covered, the description, and reason why the service is not covered is noted below. Please see your Explanation of Benefits statement for information regarding coverage for other services provided.

Note: We sent this letter to meet federal and state requirements.

Details about this service

- The total charges not paid for the service listed below is $2,750.00.
- Payment was requested for Service: 95910 Nerve Conduction Studies; 7-8 Studies with a primary diagnosis of M4726 OTHER SPONDYLOSIS WITH RADICULOPATHY, LUMBAR REGION.
- We received the claim on 05/29/2019.

- We can't pay this service because your plan doesn't cover this service. We consider it experimental, investigational or unproven for the diagnosis or diagnoses, submitted with this claim.
- A nerve conduction study (NCS) is a diagnostic test often used to check the function of motor and sensory nerves. NCS is not covered for the health problem, or health problems, sent in with this claim because there is not enough scientific proof that shows its value and/or success. At this time it is looked at as non-standard care and is considered experimental/investigational/unproven. Your benefit plan does not cover experimental/investigational/unproven testing, therapies or treatments.
- We used the Cigna Medical Coverage Policy CPG 129 Electrodiagnostic Testing (EMG/NCV) to make this decision. All Cigna Medical Coverage Policies are available online at Cigna.com.

Patient notices and rights

- In network health care providers generally cannot bill you for services found not to be medically necessary unless they told you in advance the service might not be covered and you agreed in writing to pay for it in advance of receiving the service.
- If your health care provider is not part of a network, you may receive a bill for this service.
- The requesting health care provider has been advised of this decision and given the opportunity to discuss the determination with the physician reviewer.

Appeal process

If you disagree with our decision, you can ask us to review it. You or your authorized representative must appeal within 180 days of the date of this letter (unless your health benefit plan permits a longer time). To file an appeal, follow these steps:

1. Write or call us to ask us to review our decision.
2. If you request a review in writing, please include:
   - A copy of this letter, if possible
   - Any other information you want us to consider (You or your authorized representative may have information we didn't have when we made our decision.)
3. Mail your request to:
   Cigna
   National Appeals Organization (NAO)
   P.O. Box 188011
   Chattanooga, TN 37422

A medical director who wasn't involved in making the first decision will review your request. The decision will be made according to your benefit plan.

If we deny your appeal your plan, or laws governing your plan, may allow you to appeal again. After that, you may request an external review by an independent review organization.

We'll let you know our decision, typically no later than 30 days from the date we receive your request.

Requesting records related to the claim denial

You have the right to receive free copies of all documents, records and other information related to this claim for benefits. This includes copies of the policy or guideline we used to make our decision. If you want to request copies or have questions about your appeal, please contact us by mail or phone:

- **By mail:** Cigna
  National Appeals Organization (NAO)

P.O. Box 188011
Chattanooga, TN 37422
- **By phone:** 1.800.244.6224

For information about the specific diagnosis and treatment codes your provider sent us, you can:
- Contact your provider.
- Go to Cigna.com/privacy/privacy_healthcare_forms.html.
- Call Cigna Customer Service at the number on the back of your ID card.

If this benefit plan is governed by Employee Retirement Income Security Act (ERISA), you may also have the right to bring legal action under section 502(a) of ERISA. For questions about appeal rights or for general help, you can call the Employee Benefits Security Administration at 1.866.444.EBSA (3272), or go to www.askebsa.dol.gov. If your benefit plan is a Non-Federal Governmental Plan, please call the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1.888.393.2789.

Additional Information related to the Affordable Care Act
If you're not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

Please note that these program offices may not be the offices designated to receive your request for an external review. See the external review information above if applicable.

Questions or concerns?
We're happy to help. Please call us at 1.800.244.6224, or at the toll-free number on the back of your Cigna ID card. Customer Service Advocates are available 24/7. You can also visit us at Cigna.com. If you have a hearing or speech impairment and use Telecommunications Relay Services (TRS) or a Text Telephone (TTY), dial 711 to connect with a TRS operator. Translation services are available at no cost to you.

Sincerely,

Cheryl Dopke DO

Cheryl Dopke DO
Medical Director

cc: GARY L WAGONER DC

Customer Copy

P.O. Box 188011
Chattanooga, TN 37422
- **By phone:** 1.800.244.6224

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Sincerely,

Cheryl Dopke DO

Cheryl Dopke DO
Medical Director

cc: GARY L WAGONER DC

Customer Copy

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on your ID card (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en su tarjeta de identificación (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số trên thẻ Hội viên của quý vị (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 귀하의 ID 카드에 있는 전화번호로 연락해주십시오(TTY: 다이얼 711).

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa iyong ID card (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана (TTY: 711).

Arabic – يرجى الانتباه خدمات الترجمة المجانية متاحة لكم.لعملاء Cigna الحاليين يرجى الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué sur votre carte d'identité (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no seu cartão de identificação (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na karcie identyfikacyjnej (TTY: wybierz 711).

Japanese – 注意事項：無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカードの電話番号 (TTY: 711) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali chiamare il numero riportato sulla tessera di identificazione (Utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf Ihrer Krankenversicherungskarte an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna، لطفا با شماره قید شده بر روی کارت شناسایی خود تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره گیری کنید).

905680 04/17

Cigna, ATTN: Complex Claim Unit (CCU)
7555 Goodwin Road
Chattanooga, TN 37421

Cigna

July 16, 2019

GARY L WAGONER DC
1089 16356 N THOMPSON PEAK
SCOTTSDALE, AZ 85260-2103

GET HELP FROM NCU CUSTOMER SERVICE

RE: CAITLIN WALLS
Customer ID #: U09892130
Authorization Code: Not Applicable
Patient Account #: ND1097
Service Provider: GARY L WAGONER DC
Health Care Provider Tax ID#: 27-6938695

Claim Reference	Date(s) of Service	Claim Total Charge	Charges Not Paid By Your Health Plan
4191919392000	12/11/2018 – 12/11/2018	$2,750.00	$2,750.00

Health Care Provider: This is a copy of a letter sent to the patient indicated below. If you would like to speak to a physician reviewer about this decision, please call us at 1.800.558.7390 Option #3. However, please be aware that the physician reviewer will only have available the limited information supplied on the claim. Therefore, your two best options to have this decision reconsidered may be to resubmit the claim using a covered service code or to appeal this decision as directed in this letter.

Cigna Health Management, Inc., on behalf of PINNACLE WEST CAPITAL CORPORATION

Dear CAITLIN WALLS,

We received claim 4191919392000 for services received between 12/11/2018 – 12/11/2018 from GARY L WAGONER DC. You are receiving this letter because, as noted on your Explanation of Benefits, there is a service we cannot cover under your benefit plan because it is considered experimental, investigational or unproven for the diagnosis. The dollar amount of the service not covered, the description, and reason why the service is not covered is noted below. Please see your Explanation of Benefits statement for information regarding coverage for other services provided.

Note: We sent this letter to meet federal and state requirements.

PXDX-01

external organization to review it. This depends on your health plan and any federal or state requirements. External reviews may be expedited.

Requesting records related to the claim denial
You have the right to receive free copies of all documents, records and other information related to this claim for benefits. This includes copies of the policy or guideline we used to make our decision. If you want to request copies or have questions about your appeal, please contact us by mail or phone:

- **By mail:** Cigna
  National Appeals Organization (NAO)
  P.O. Box 188011
  Chattanooga, TN 37422
- **By phone:** 1.800.244.6224

For information about the specific diagnosis and treatment codes your provider sent us, you can:

- Contact your provider.
- Go to Cigna.com/privacy/privacy_healthcare_forms.html.
- Call Cigna Customer Service at the number on the back of your ID card.

If this benefit plan is governed by Employee Retirement Income Security Act (ERISA), you may also have the right to bring legal action under section 502(a) of ERISA. For questions about appeal rights or for general help, you can call the Employee Benefits Security Administration at 1.866.444.EBSA (3272), or go to www.askebsa.dol.gov. If your benefit plan is a Non-Federal Governmental Plan, please call the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1.888.393.2789.

Additional Information related to the Affordable Care Act
If you're not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

Please note that these program offices may not be the offices designated to receive your request for an external review. See the external review information above if applicable.

Questions or concerns?
We're happy to help. Please call us at 1.800.244.6224, or at the toll-free number on the back of your Cigna ID card. Customer Service Advocates are available 24/7. You can also visit us at Cigna.com. If you have a hearing or speech impairment and use Telecommunications Relay Services (TRS) or a Text Telephone (TTY), dial 711 to connect with a TRS operator. Translation services are available at no cost to you.

Sincerely,

Cheryl Dopke DO

Details about this service

- The total charges not paid for the service listed below is $2,750.00.
- Payment was requested for Service: 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report with a primary diagnosis of M5416 RADICULOPATHY, LUMBAR REGION.
- We received the claim on 07/12/2019.
- We can't pay this service because your plan doesn't cover this service. We consider it experimental, investigational or unproven for the diagnosis or diagnoses, submitted with this claim.
- A nerve conduction study (NCS) is a diagnostic test often used to check the function of motor and sensory nerves. NCS is not covered for the health problem, or health problems, sent in with this claim because there is not enough scientific proof that shows its value and/or success. At this time it is looked at as non-standard care and is considered experimental/investigational/unproven. Your benefit plan does not cover experimental/investigational/unproven testing, therapies or treatments.
- We used the Cigna Medical Coverage Policy CPG 129 Electrodiagnostic Testing (EMG/NCV) to make this decision. All Cigna Medical Coverage Policies are available online at Cigna.com.

Patient notices and rights

- In network health care providers generally cannot bill you for services found not to be medically necessary unless they told you in advance the service might not be covered and you agreed in writing to pay for it in advance of receiving the service.
- If your health care provider is not part of a network, you may receive a bill for this service.
- The requesting health care provider has been advised of this decision and given the opportunity to discuss the determination with the physician reviewer.

Appeal process

If you disagree with our decision, you can ask us to review it. You or your authorized representative must appeal within 180 days of the date of this letter (unless your health benefit plan permits a longer time). To file an appeal, follow these steps:

1. Write or call us to ask us to review our decision.
2. If you request a review in writing, please include:
   - A copy of this letter, if possible
   - Any other information you want us to consider (You or your authorized representative may have information we didn't have when we made our decision.)
3. Mail your request to:
   Cigna
   National Appeals Organization (NAO)
   P.O. Box 188011
   Chattanooga, TN 37422

A medical director who wasn't involved in making the first decision will review your request. The decision will be made according to your benefit plan.

- If you appeal, a doctor will review your request. This doctor doesn't work for or report to the doctor who made this first decision.
- The reviewer will make a decision no later than 30 days from when we receive your request.
- We'll mail you a letter with the decision within 30 days of your request.

Independent external reviews

If you're not satisfied with our final decision, you may be able to ask for an independent,

Cigna, ATTN: Complex Claim Unit (CCU)
7555 Goodwin Road
Chattanooga, TN 37421

Cigna

July 16, 2019

CAITLIN WALLS
5609 W DESPERADO WAY
PHOENIX, AZ 85083-0000

RE: CAITLIN WALLS
Customer ID #: U09892130
Authorization Code: Not Applicable
Patient Account #: ND1097
Service Provider: GARY L WAGONER DC
Group Account #: 3341058

Claim Reference	Date(s) of Service	Claim Total Charge	Charges Not Paid By Your Health Plan
4191919392000	12/11/2018 – 12/11/2018	$2,750.00	$2,750.00

Cigna Health Management, Inc., on behalf of PINNACLE WEST CAPITAL CORPORATION

Dear CAITLIN WALLS,

We received claim 4191919392000 for services received between 12/11/2018 – 12/11/2018 from GARY L WAGONER DC. You are receiving this letter because, as noted on your Explanation of Benefits, there is a service we cannot cover under your benefit plan because it is considered experimental, investigational or unproven for the diagnosis. The dollar amount of the service not covered, the description, and reason why the service is not covered is noted below. Please see your Explanation of Benefits statement for information regarding coverage for other services provided.

Note: We sent this letter to meet federal and state requirements.

Details about this service

- The total charges not paid for the service listed below is $2,750.00.
- Payment was requested for Service: 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each

external organization to review it. This depends on your health plan and any federal or state requirements. External reviews may be expedited.

Requesting records related to the claim denial
You have the right to receive free copies of all documents, records and other information related to this claim for benefits. This includes copies of the policy or guideline we used to make our decision. If you want to request copies or have questions about your appeal, please contact us by mail or phone:

- **By mail:** Cigna
  National Appeals Organization (NAO)
  P.O. Box 188011
  Chattanooga, TN 37422
- **By phone:** 1.800.244.6224

For information about the specific diagnosis and treatment codes your provider sent us, you can:

- Contact your provider.
- Go to Cigna.com/privacy/privacy_healthcare_forms.html.
- Call Cigna Customer Service at the number on the back of your ID card.

If this benefit plan is governed by Employee Retirement Income Security Act (ERISA), you may also have the right to bring legal action under section 502(a) of ERISA. For questions about appeal rights or for general help, you can call the Employee Benefits Security Administration at 1.866.444.EBSA (3272), or go to www.askebsa.dol.gov. If your benefit plan is a Non-Federal Governmental Plan, please call the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at 1.888.393.2789.

Additional Information related to the Affordable Care Act
If you're not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

Please note that these program offices may not be the offices designated to receive your request for an external review. See the external review information above if applicable.

Questions or concerns?
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Sincerely,

Cheryl Dopke DO

Details about this service

- The total charges not paid for the service listed below is $2,750.00.
- Payment was requested for Service: 95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report with a primary diagnosis of M5416 RADICULOPATHY, LUMBAR REGION.
- We received the claim on 07/12/2019.
- We can't pay this service because your plan doesn't cover this service. We consider it experimental, investigational or unproven for the diagnosis or diagnoses, submitted with this claim.
- A nerve conduction study (NCS) is a diagnostic test often used to check the function of motor and sensory nerves. NCS is not covered for the health problem, or health problems, sent in with this claim because there is not enough scientific proof that shows its value and/or success. At this time it is looked at as non-standard care and is considered experimental/investigational/unproven. Your benefit plan does not cover experimental/investigational/unproven testing, therapies or treatments.
- We used the Cigna Medical Coverage Policy CPG 129 Electrodiagnostic Testing (EMG/NCV) to make this decision. All Cigna Medical Coverage Policies are available online at Cigna.com.

Patient notices and rights

- In network health care providers generally cannot bill you for services found not to be medically necessary unless they told you in advance the service might not be covered and you agreed in writing to pay for it in advance of receiving the service.
- If your health care provider is not part of a network, you may receive a bill for this service.
- The requesting health care provider has been advised of this decision and given the opportunity to discuss the determination with the physician reviewer.

Appeal process

If you disagree with our decision, you can ask us to review it. You or your authorized representative must appeal within 180 days of the date of this letter (unless your health benefit plan permits a longer time). To file an appeal, follow these steps:

1. Write or call us to ask us to review our decision.
2. If you request a review in writing, please include:
   - A copy of this letter, if possible
   - Any other information you want us to consider (You or your authorized representative may have information we didn't have when we made our decision.)
3. Mail your request to:
   Cigna
   National Appeals Organization (NAO)
   P.O. Box 188011
   Chattanooga, TN 37422

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Cigna

July 16, 2019

CAITLIN WALLS
5609 W DESPERADO WAY
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RE: CAITLIN WALLS
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Authorization Code: Not Applicable
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PXDX-01

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Sincerely,

Cheryl Dopke DO

Cheryl Dopke DO
Medical Director

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Cigna.

Cigna.

If you have difficulty reading English, we offer language assistance. For help please call the Customer Service number on your ID card.

Si tiene problemas para leer el texto en inglés, le ofrecemos asistencia de idiomas. Para obtener ayuda, por favor, llame al número de Servicio al cliente que figura en su tarjeta de identificación.

Si vous avez des difficultés à lire l'anglais, nous offrons une assistance linguistique. Pour toute aide, veuillez composer le numéro du Service à la clientèle qui se trouve sur votre carte d'identification.

Für den Fall, dass Sie den englischen Text nicht verstehen, bieten wir mehrsprachige Unterstützung an. Rufen Sie in diesem Fall bitte die auf Ihrer Versicherungskarte angegebene Kundenservice-Nummer an.

Kung nahihirapan ka sa pagbabasa ng wikang Ingles, nag-aalok kami ng tulong sa wika. Para sa tulong pakitawagan ang numero ng Serbisyo ng Customer sa iyong ID card.

如果對您來說閱讀英文會有困難，我們可以提供您語言協助。欲取得協助，請撥打會員卡上的客戶服務電話號碼。

Bilagáana Bizaad wólta' nil nanitl'ahgo, saad bee niká'a'doowołígíí hóló. Áká'a'áyeed biniiyé t'áá shǫǫdi áká'anídaalwo'go dabinaanishígíí bich'į' hodíílnih éí naaltsoos bee nee hózinígíí bikáa'gi bibéésh bee haane'é yisdzoh.

Cigna
Appeals
PO Box 188011
Chattanooga, TN 37422

November 21, 2020

Caitlin Walls
5609 W Desperado Way
Phoenix AZ 85083-7324

RE: Cigna Health and Life Insurance Company on behalf of your Employer Plan

Name: Caitlin Walls
ID #: U09892130
Provider: Gary L Wagoner, DC
Dates of Service: 12/11/2018
SR #: 1246743719
Claim Amount: $2,750.00

Dear Caitlin,

On September 28, 2020, we received an appeal request concerning our decision to deny the procedure code 95910 (nerve transmission studies, 7-8 studies) provided to you by Gary L Wagoner, DC with diagnosis code G61.0.

Appeal Decision
After reviewing the appeal submitted by Dr Gary L Wagoner, the original decision to deny the procedure code 95910 provided to you on December 11, 2018 is upheld. All the original information in your file, the information submitted with this request and the terms of your benefit plan were reviewed.

More About The Decision
This decision was made on November 21, 2020 by Gretchen G., Appeals Processor.

This decision was based on the following:

1

We are denying your request for an appeal. We must receive an appeal request within a certain timeframe. This timeframe is one hundred eighty (180) calendar days from the date we processed your claim, prepared the explanation of benefits (EOB) statement or sent an adverse determination (denial) letter. The date of the denial letter was January 9, 2019. We received your appeal request too late after the deadline.

According to your Pinnacle West Capital Corporation Summary of Benefit Plans Booklet, under the section "Appealing a Denial of Benefits", it states:

Post-Service Claims
If Your Post-Service Claim is Denied
If your post-service claim is denied, you may appeal that decision to the Claims Administrator. If you decide to appeal, your appeal must be made in writing and postmarked within 180 calendar days from the date of written notification from the Claims Administrator. As part of your appeal, you should provide any supporting documentation you may have, including information which was not previously provided. You may also review and receive copies of relevant information and review your claim file by following the procedures described in other parts of this Other Plan Facts section.

If you do not appeal the Claims Administrator's decision within 180 calendar days from the date of notification, you will be deemed to have accepted that decision.

For More Information
If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to http://www.cigna.com/privacy/privacy_healthcare_forms.html or call the Customer Service number on the back of your ID card.

You are entitled to receive free of charge, copies of all documents, records and other information relevant to your appeal for benefits. This includes the benefit provision, guideline or protocol upon which the decision was made. If you want to request this material, or if you have any questions, please write to us at:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422

You may also call our Customer Service Department at the toll-free number listed on your Cigna ID card. We'll be happy to help you.

Sincerely,

Gretchen G.
Appeals Processor

Cigna

Provider Explanation of Medical Benefits Report

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
276938695 0003	STARBOARD ATTITUDE TRUST	07/13/2019		1

line	Procedure Date	Procedure Code	Adjusted Procedure Code	Billed Amount	Adjusted Procedure Code Amount	Allowed Amount	Not Covered/ Discount	Deduct/Copay Amount	Coinsurance Amount	DRG / Per Diem / APC Type	DRG / Per Diem / APC Number	DRG/Per Diem Amount	DRG/ Per Diem Benefit Amount	Plan Benefit	See Note
	Reminder: A coverage determination, prior authorization, or certification that is made prior to a service being performed is not a promise to pay for the service at any particular rate or amount. The patient's summary plan description governs amount payable, as every claim submitted is subject to all plan provisions, including, but not limited to, eligibility requirements, exclusions, limitations, and applicable state mandates.														
	PATIENT NAME: CAITLIN WALLS PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER SUBSCRIBER NAME: CAITLIN WALLS				PATIENT#: ND1097 PROVIDER NETWORK STATUS: OUT OF NETWORK SUBSCRIBER#: U09892130				OPERATION LOCATION/GROUP# 56331-9-3341058 RECEIVE DATE: 07/12/2019 PROCESS DATE: 07/13 REF#: 4191919392000						
1	12112018	95905		2750.00		2750.00						0.00	0.00	0.00 0.00	A0
	TOTAL			2750.00		2750.00									

BALANCE..... $2,750.00

** NOTES ON BENEFIT DETERMINATION:
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

SYS-BSB

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWERS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.COM)

A0) THIS SERVICE IS NOT COVERED BECAUSE IT IS CONSIDERED EXPERIMENTAL, INVESTIGATIONAL OR UNPROVEN FOR ALL INDICATIONS.

Cigna

rovider Explanation of Medical Benefits Report

Provider Number	Provider Name	Date through which claims were processed	THIS IS NOT A BILL Retain for Your Records	Page
276938695 0003	STARBOARD ATTITUDE TRUST	01/09/2019		1

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	PATIENT NAME: CAITLIN WALLS PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER SUBSCRIBER NAME: CAITLIN WALLS				PATIENT#: 1836032367 PROVIDER NETWORK STATUS: OUT OF NETWORK SUBSCRIBER#: U09892130						OPERATION LOCATION/GROUP# 56331-9-3341058 RECEIVE DATE: 12/13/2018 PROCESS DATE: 01/09 REF#: 4191834890829					
1	12112018	96910		2750.00								0.00	0.00	0.00 0.00	A0
	TOTAL			2750.00				2750.00							

BALANCE..... $2,750.00

** NOTES ON BENEFIT DETERMINATION:
THIS IS A CORRECTION OF A PREVIOUSLY PROCESSED CLAIM.
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE
REFERENCE NUMBER ON INQUIRIES.
MN2-RLO

VIEW ELIGIBILITY, BENEFITS, AND CLAIM DETAILS AND GET PRECERTIFICATION ANSWE
RS FAST AT THE CIGNA FOR HEALTH CARE PROFESSIONALS WEBSITE (WWW.CIGNAFORHCP.
COM)

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INDICATIONS.

Cigna

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Provider Number	Provider Name	Date through which claims were processed		Page
276938695 0003	STARBOARD ATTITUDE TRUST	01/09/2019	THIS IS NOT A BILL Retain for Your Records	1

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	PATIENT NAME: CAITLIN HALLS PATIENT'S RELATIONSHIP TO SUBSCRIBER: SUBSCRIBER SUBSCRIBER NAME: CAITLIN HALLS				PATIENT#: 1846739890 PROVIDER NETWORK STATUS: OUT OF NETWORK SUBSCRIBER#: U09892130				OPERATION LOCATION/GROUP# 56331-9-3341058 RECEIVE DATE: 12/30/2018 PROCESS DATE: 01/09 REF#: 4191836590718						
1	12112018	95910		2750.00			2750.00					0.00	0.00	0.00	A0
	TOTAL			2750.00			2750.00							0.00	

BALANCE..... $2,750.00

MM NOTES ON BENEFIT DETERMINATION:
IF YOU HAVE ANY QUESTIONS REGARDING THIS CLAIM, PLEASE INCLUDE THE REFERENCE NUMBER ON INQUIRIES.

MN2-RLO

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Cigna, ATTN: Complex Claim Unit (CCU)
7555 Goodwin Road
Chattanooga, TN 37421

January 11, 2019

GARY L WAGONER DC
1089 16356 N THOMPSON PEAK
SCOTTSDALE, AZ 85260-2103

RE: CAITLIN WALLS
Customer ID #: U09892130
Authorization Code: Not Applicable
Patient Account #: 1846739890
Service Provider: GARY L WAGONER DC
Health Care Provider Tax ID#: 27-6938695

Claim Reference	Date(s) of Service	Claim Total Charge	Charges Not Paid By Your Health Plan
4191836590718	12/11/2018 – 12/11/2018	$2,750.00	$2,750.00

940130323101

Health Care Provider: This is a copy of a letter sent to the patient indicated below. If you would like to speak to a physician reviewer about this decision, please call us at 1.800.558.7390 Option #3. However, please be aware that the physician reviewer will only have available the limited information supplied on the claim. Therefore, your two best options to have this decision reconsidered may be to resubmit the claim using a covered service code or to appeal this decision as directed in this letter.

Cigna Health Management, Inc., on behalf of PINNACLE WEST CAPITAL CORPORATION

Dear CAITLIN WALLS,

We received claim 4191836590718 for services received between 12/11/2018 – 12/11/2018 from GARY L WAGONER DC. You are receiving this letter because, as noted on your Explanation of Benefits, there is a service we cannot cover under your benefit plan because it is considered experimental, investigational or unproven for the diagnosis. The dollar amount of the service not covered, the description, and reason why the service is not covered is noted below. Please see your Explanation of Benefits statement for information regarding coverage for other services provided.

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Additional Information related to the Affordable Care Act
If you're not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.

Your state may also offer a consumer assistance or an Ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, **and select "State Ombudsman/Consumer Assistance Programs" from the drop down** menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your Cigna ID card.

Please note that these program offices may not be the offices designated to receive your request for an external review. See the external review information above if applicable.

Questions or concerns?
We're happy to help. Please call us at 1.800.244.6224, or at the toll-free number on the back of your Cigna ID card. Customer Service Advocates are available 24/7. You can also visit us at Cigna.com. If you have a hearing or speech impairment and use Telecommunications Relay Services (TRS) or a Text Telephone (TTY), dial 711 to connect with a TRS operator. Translation services are available at no cost to you.

Sincerely,

Paul Rossi DO

Paul Rossi DO
Medical Director

cc: GARY L WAGONER DC

940130323102

Cigna Health and Life Insurance Company
PHOENIX CLAIM OFFICE
P.O. BOX 182223
CHATTANOOGA, TN 37422-7223

Cigna Health and Life Insurance Company
AS AGENT FOR:

APS

Provider Number:
276938695 0003

Date through which claims were processed:
JANUARY 9, 2019

Remittance Tracking Number:

STARBOARD ATTITUDE TRUST
1089
16356 N THOMPSON PEAK PKWY APT 1089
SCOTTSDALE AZ 85260-2103

How to Contact Us
Mail to the return address in upper left corner of this page
http://www.cigna.com
Phone: (800) 477-4277

Provider Explanation of Medical Benefits

Understanding this Benefits Statement

This page provides a summary of the payments made this period.

The accompanying pages give more detail on the claims we processed for this period. Please review both the front and back of each page to see how the benefit amounts shown in the Explanation of Medical Benefits Report were determined.

In the event a claim is denied.....

Rights of Review and Appeal - For Physician or Health Care Provider

If you have questions or disagree with the payment identified on this Explanation of Medical Benefits statement, you may ask to have it reviewed.

If you have a contractual agreement with Cigna HealthCare, please refer to the procedural guidelines associated with your Cigna HealthCare contract, or call our office for assistance.

Federal Rights of Review and Appeal - For Employee

- Call Member Services at the toll free number on this Explanation of Benefits (EOB) or your ID card if you have questions regarding this EOB.
- If you're not satisfied with this coverage decision, you can start the Appeal process by submitting a written request to the address listed in your plan materials within 180 days of receipt of this EOB (unless a longer time is permitted by state law or your plan).
- Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.
- Be sure to include your 1) Name, 2) Operation Location/Group Number, 3) Employee/Patient ID number, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- You are entitled to receive free upon request access to , and copies of, all documents, records and other information relevant to your claim for benefits.
- You will be notified of the final decision in a timely manner, as described in your plan materials. If your plan is governed by ERISA, you also have the right to bring legal action under section 502(a) of ERISA following our review.

Provider Summary

No Payment was made with this statement

The charges submitted were negated or offset by the deductibles, coinsurance, etc., or the patient(s) may be incurring liability for payment. See the following provider detail page for an explanation of how the benefits were determined.

Cigna Health and Life Insurance Company
PHOENIX CLAIM OFFICE
P.O. BOX 182223
CHATTANOOGA, TN 37422-7223

Cigna Health and Life Insurance Company
AS AGENT FOR:

APS

Cigna®

Provider Number:
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3450303216803

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- Send a copy of this EOB along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. Contact Member Services if you need further instructions on how and where to send your request for review.
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Provider Summary

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The charges submitted were negated or offset by the deductibles, coinsurance, etc., or the patient(s) may be incurring liability for payment. See the following provider detail page for an explanation of how the benefits were determined.

Dr. Gary L. Wagoner (Starboard Attitude Trust)
702 E. Bell Rd. # 112
Phoenix, Az. 85022
(480) 343-0585
fax (310) 598-3160

Peer-to-Peer Request with like Provider Specialist

RE: Caitlin Walls
Cigna ID# U0989213001 (ERISA policy)
DOB: 06/04/1985
Date of service: 12/11/2018
CPT: 95910 to bilateral lower extremities

7/29/19

Dear National Appeals Unit,

My name is Dr. Gary L. Wagoner, DC, and I am requesting an expedited peer-to-peer conversation with another chiropractor regarding a claim denial for patient Caitlin Walls for date of service 12/11/2018 for a nerve conduction velocity test (NCV) that has already been performed with CPT 95910 of the bilateral lower extremities.

I have attached the EOB in question to this letter that states that the performed NCV is considered experimental by your company. I have also attached SOAP notes from two Pain Management specialist and my SOAP notes prior to the NCV test, along with your own guidelines from your contracted TPA American Speciality Health which clearly state your clinical rational for the NCV test. When all of these documents are read in full there is no logical clinical reason to deny this test or to consider the examination to be experimental. The proper CPT code has been used vs the proper diagnosis codes and these code combinations are clearly stated in your ASH NCV policy Electrodiagnostic Testing (EMG/NCV) (CPG 129) see attached documents.

I am also sending a copy of this request to the patient and to the patients employer for their records since this is an ERISA policy.

Please contact me as soon as possible.

Respectfully submitted,

Dr. Gary L. Wagoner
Gary L. Wagoner, DC

cc: Caitlin Walls
APS Arizona Public Services

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Cigna HealthCare®, its agents or subsidiaries to disclose the Protected Health Information (PHI) indicated below to the persons or entities specified on this form.

Please note: This form is not required for all releases of your PHI. For example, this form may not be required to release information to:

- A spouse of a Customer, when both are covered by the Cigna HealthCare plan
- Parents of minors or other dependents
- Personal Representative on file with Cigna HealthCare

We will disclose certain PHI about you to these persons upon their request if they successfully complete a caller verification process. Please print your responses on this form. **All sections must be completed for this authorization to be valid.**

1. Verification

Identification of Customer: *(The following information is needed for verification.)*

Name of Customer whose information will be disclosed: CAITLIN WALLS

Date of Birth: 6-4-1985

Customer Address: 5609 W. DESPERADO WAY PHOENIX, AZ. 85083

Phone Number where we can reach you if we need to contact you to process your request (required): 480/343-0585

Social Security # (Optional): _____ **Customer ID card #** (if applicable): U0989213001

Group or Account # on ID Card: 3341058

Subscriber Name (if different from Customer): _____

Subscriber's Employer: APS **Subscriber's Relationship to Customer:** _____

Subscriber's Social Security # (if different from customer) (Optional): _____

If you have additional coverage with Cigna, other than that which is described above, please provide the following information as well:

Other Employer Name: N-A

Customer ID Card #: _____ **Group or Account # on ID Card:** _____

Does this request apply to all coverage? ☒ Yes ☐ No

Together, all the way.®

Cigna

2. Description of Information to be Released

Please indicate what information you wish to release by checking one or more of the boxes below. If you wish to grant limited access (i.e., specific dates of service, specific case management issues, etc.), please specify that in the space provided.

☒ **Claims:** All claims information for all dates of service for 2018, 2019, 2020 and 2021

☒ **Eligibility/Benefits:** All eligibility / benefits information for all dates of service for 2018, 2019, 2020 and 2021

☒ **Medical Records:** All medical records for all dates of service for 2018, 2019, 2020 and 2021

☒ **Case Management:** All case management information for all dates of service for 2018, 2019, 2020 and 2021

☒ **Other:** All Allowed Amounts for all CPT codes billed for all dates of service for 2018, 2019, 2020 and 2021

Unless otherwise indicated, my authorization includes the release of the following: *(Please strike through those you wish to exclude, if any.)*

- Diagnosis and/or treatment for alcoholism and/or drug abuse or dependency
- Diagnosis and/or treatment of mental illness
- HIV antibody test results and/or AIDS diagnosis and treatment
- Genetic testing information

Arizona residents – The information authorized for release may include records concerning a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Arizona Revised Statutes 36-664 if this type of information is to be released.

Oklahoma residents – The information authorized for release may include records concerning a communicable or venereal disease, which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and HIV/AIDS. You may have additional protections under Section 1-502.2 of the Oklahoma Statutes if this type of information is to be released.

3. Entity or person authorized to receive information

Name: DR. GARY WAGONER **Company** (if applicable): _____

Address of Individual or Company authorized to receive the information: 16356 N. Thompson Peak #1089 Scottsdale, AZ 85260

Virginia residents – A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with your original health records.

4. Purpose of this release of information

☒ **At the request of the individual**

☐ **Other** (please describe) _____

If the expiration date is omitted from this form, your authorization will expire after one year and a new authorization will need to be submitted at that time.

5. Expiration of Authorization

This authorization expires: 2-11-2022 (date or event).

If you state an event rather than a specific date, it will be necessary for you to submit a revocation form when the event occurs.

Note for customers in the following states: If you live in **Arizona, California, Georgia, Illinois, Massachusetts, Montana** or **Minnesota**, your authorization will be valid for no more than one year. Authorizations signed by **Virginia** residents will be valid for no more than two years. Customers living in those states who seek to authorize disclosure of their personal information for a longer period will have to submit a new authorization at the time that this authorization expires.

Please note

- Information disclosed based on this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.
- If the information on this form is not complete, Cigna HealthCare will return the form to you, and this request will not be considered until Cigna HealthCare receives complete information.
- If your Customer ID or date of birth is changed, another form will need to be completed at that time.
- If either the Customer or Group changes to a different type of health care benefits coverage provided by Cigna HealthCare, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to Cigna HealthCare, Central HIPAA Unit, at the address below. You can obtain a Change/Revoke form by calling Cigna HealthCare Customer Service at the number on your Cigna HealthCare ID card.
- The provision of treatment, payment enrollment or eligibility for benefits does not depend on whether you sign this authorization.

I have read and understand the above information.

My signature authorizes the disclosure of the information described.

6. Signature of Customer, Personal Representative, Parent/Guardian who is authorizing the release:

_____ Date: 2-10-2021

Relationship if the person signing is other than Customer whose information is to be used and disclosed: _____

- If this request is made by a Personal Representative, we will require verification of the authority of that Personal Representative before this request will be considered complete.
- If request is made by a parent/guardian, please complete the following: Customer is a minor, _____ years of age. If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.

We recommend that you keep a copy of your completed form for your records. A copy will be retained by Cigna HealthCare and made available upon your request.

Please return this completed form:

Fax to: 877.815.4827 or 859.410.2419

or

Mail to: Cigna HEALTHCARE CENTRAL HIPAA UNIT,
PO Box 188014,
Chattanooga, TN 37422.

Cigna.

Dr. Gary L. Wagoner
16356 N. Thompson Peak Pkwy #1089
Scottsdale, Az. 85260
480/343-0585
fax 310/598-3160
drgarydcbh@yahoo.com

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

• In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. Gary Wagoner/Starboard Attitude Trust, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

• I hereby convey to the above named provider Dr. Gary Wagoner/Starboard Attitude Trust to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with Dr. Gary Wagoner/Starboard Attitude Trust in any attempts by Dr. Gary Wagoner/Starboard Attitude Trust to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at Dr. Gary Wagoner/Starboard Attitude Trust expenses.

• This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signed: Garrett Wells

Date: 08/17/19

Dr. Gary L. Wagoner
16356 N. Thompson Peak Pkwy #1089
Scottsdale, Az. 85260
480/343-0585
fax 310/598-3160
drgarydcbh@yahoo.com

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• In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Dr. Gary Wagoner/Starboard Attitude Trust, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

• I hereby convey to the above named provider Dr. Gary Wagoner/Starboard Attitude Trust to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with Dr. Gary Wagoner/Starboard Attitude Trust in any attempts by Dr. Gary Wagoner/Starboard Attitude Trust to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at Dr. Gary Wagoner/Starboard Attitude Trust expenses.

• This lifetime assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

Signed: Garrett Wells

Date: 08/17/19

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Cigna Executive Office
PO Box 188016
Chattanooga, TN 37422

Cigna.

August 28, 2019

Starboard Attitude Trust/Dr. Gary Wagoner
16356 N Thompson Peak # 1089
Scottsdale AZ 85260

Provider: Dr. Gary Wagoner
Tracking ID: 1161113596
Patient: Caitlin Walls

Thank you for bringing your concerns to the attention of the Executive Office at Cigna.

Dear Dr. Wagoner,

I want to let you know that I received your letter addressed to David Cordani on August 28, 2019. I'm a part of the Executive Office Advocacy Team. My job is to look into the concerns Cigna customers, and their representatives, bring to the attention of our president and senior leadership team. I look forward to helping you with this issue.

Summary of Your Concern
I understand your concern is regarding services rendered on December 11, 2018.

Next Steps
I'm going to spend some time looking into this issue. Expect to hear back from me by September 12, 2019. This gives me a chance to fully research your issue.

You're Important To Us
In the meantime, you can call me at 1-800-446-6633 with any questions. Thank you again for sharing your concerns with the Executive Office at Cigna.

Sincerely,

Carrie Lewis
Executive Office Advocacy Team

Enclosure: Non-Discrimination and Language Assistance Notice

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

896375a 05/17

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Cigna
PO Box 3050
Easton, PA 18043

STARBOARD ATTITUDE TRUST
16356 N THOMPSON PEAK # 1089
SCOTTSDALE AZ 85260-2103

000092

Cigna
Appeals
PO Box 188011
Chattanooga, TN 37422

Cigna.

February 3, 2022

***The appeals process has NOT been exhausted. But Cigna states an IRO is the next option. glw

Caitlin Walls
5609 W Desperado Way
Phoenix AZ 85083-7324

RE: Cigna Health Management, Inc. on behalf of Your Employer Plan

Name: Caitlin Walls
ID #: U09892130
Provider: Gary L Wagoner DC
Dates of Service: 12/11/2018
SR #: 1329937499
Claim Amount: $2,750.00

1227400000802

Dear Caitlin,

On October 26, 2021, we received an appeal request concerning our decision to deny coverage for Current Procedural Terminology (CPT) code 95910 [Nerve Conduction Studies; 7-8 Studies] provided by Gary L Wagoner DC on 12/11/2018 with diagnosis code G61.0.

Appeal Decision
After reviewing the appeal submitted by Gary L Wagoner DC, the original decision to deny coverage for CPT code 95910 on 12/11/2018 is upheld. All the original information in your file, the information submitted with this request and the terms of your benefit plan were reviewed.

Please know that a physician board certified in Family Medicine also reviewed your information and agrees with this decision.

More About The Decision
This decision was made on February 3, 2022 by an Appeals Committee. Attached is a list of individuals who participated on the Appeals Committee along with their titles and credentials.

X This decision was based on the following:

X All of the information submitted previously and with this appeal was reviewed both by the committee and by an internal reviewer board certified in

X Chiropractics. As previously noted in the denial letter you received, nerve conduction velocity (NCV) testing is considered by the current Cigna guideline to be medically necessary when performed alone for an individual with any of these conditions:
-myopathy (muscle disease) such as, polymyositis, dermatomyositis, myotonic myopathy, congenital myopathy
-disorder of brachial or lumbosacral plexus (nerves in the neck or lower back)
-plexopathy (a type of nerve disorder)
-focal neuropathy, entrapment neuropathy, compressive lesion/syndrome, including but not limited to any of these after failure of 4-6 weeks of conservative therapy:
--carpal tunnel
--cubital tunnel syndrome
--tarsal tunnel syndrome
--peroneal nerve compression
--thoracic outlet syndrome
-diagnosis or confirmation of a generalized neuropathy, including but not limited to any of these:
--metabolic and nutritional [diabetic, uremic, amyloidosis, hypothyroidism, immune, vitamin B12 or thiamine deficiency])
--toxic neuropathy (e.g., vincristine, amiodarone)
--hereditary polyneuropathy (e.g., Charcot-Marie Tooth disease)
--infectious neuropathy (e.g., HIV, Lyme disease, Leprosy)
--demyelinating neuropathy (e.g., Guillain-Barre syndrome)
--idiopathic peripheral neuropathy
-repetitive stimulation in the diagnosis of a neuromuscular junction disorder (e.g., myasthenia gravis, myasthenic syndrome, botulism)
-neurotrauma (e.g., traumatic nerve lesion)
-symptom-based presentation suggesting nerve root, peripheral nerve, muscle, or neuromuscular junction involvement, when pre-test evaluations are inconclusive (not clear) and physical exam supports the need for the study
-motor neuron disease (e.g., amyotrophic lateral sclerosis)
-spine disorder and both of these:
--imaging studies confirm nerve root impingement
--any one of these:
---to differentiate radiculopathy from other neuropathies or non-neuropathic processes
---to establish whether imaging findings are responsible for reported pain
---to reconcile when pattern of pain, sensory impairment, or weakness does not match imaging findings
---to document degree of axonal nerve damage in an individual with weakness

-ANY of the above indications, in ANY of these clinical presentations:
--current use of an anticoagulant
--presence of lymphedema
--carpal tunnel syndrome with BOTH of these:
---with high pre-test probability (eg, positive Tinel's, thenar muscle atrophy or paresthesias in the radial three digits)
---after failure of 4-6 weeks of conservative care (e.g., physical therapy, exercise, bracing).

- From the clinical information received, medical necessity for this testing has not been established per the Cigna guidelines because the records do not show objective evidence of any of the above indications in the setting of any of the above clinical presentations.
- Guideline used: Cigna Medical Coverage Policy –CPG 129 Therapy Services Electrodiagnostic Testing (EMG/NCV)
- According to your APS Booklet, under the section "Other Exclusions" and "Definitions" it states:
The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.
Review all Benefit limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.
Note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not the Claims Administrator's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."
• Health services and supplies that do not meet the definition of a Covered Health Service, see definitions above. Covered Health Services includes services or supplies which the Claims Administrator determines to be all of the following:
• medically Necessary;
• described as a Covered Health Service in this SPD;
and
• not otherwise excluded in this SPD.
"Medically Necessary" means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:
• In accordance with Generally Accepted Standards of Medical Practice;
• Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
• Not mainly for your convenience or that of your doctor or other health care provider;
and
• Not more costly than an alternative drug, services(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.
Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature

generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.
If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.
The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on mycigna.com or by calling the number on your ID card, and to Physicians and other health care professionals on cigna.com.

For More Information
If you would like to request information about the specific diagnosis and treatment codes submitted by your Health Care Professional, please either contact your Health Care Professional, or go to http://www.cigna.com/privacy/privacy_healthcare_forms.html or call the Customer Service number on the back of your ID card.

For more detailed information, please refer to our Clinical Policy section on http://www.Cigna.com/customer_care/healthcare_professional/coverage_positions/index.html

You are entitled to receive free of charge, copies of all documents, records and other information relevant to your appeal for benefits. This includes the benefit provision, guideline or protocol upon which the decision was made. If you want to request this material, or if you have any questions, please write to us at:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422

You may also call our Customer Service Department at the toll-free number listed on your ID card. We'll be happy to help you.

Sincerely,

Douglas C. Leavengood

Douglas C. Leavengood, MD
Medical Director
Board Certified in Internal Medicine
Board Certified in Allergy and Immunology

Enclosures: Your Rights and Other Important Information About an Appeal
Language Assistance Form
Non-Discrimination and Language Assistance Notice
Request for IRO Review and Release Form

c: Gary L. Wagoner, DC

APPEALS COMMITTEE MEMBERS

Title	Credentials
Medical Principle	MD
Utilization Review Nurse I	RN
Appeals Processing Senior Representative	Non-Clinician

***There are no names of the so-called "Appeals Committee" except from the medical director. The previous paragraph states that the names of the "committee" members are noted. However, there are no other names. This letter is a lie and violates ERISA and A.R.S. Title 20.

Your Rights and Other Important Information About An Additional Appeal

This decision represents the final step of the **internal** appeal process. Your employer's plan provides for external review of some types of claims if a request is filed within four (4) months of the final internal appeal denial. External review is available only if a claim denial involves "medical judgment" or a rescission of coverage. Under a federal law known as the Employee Retirement Income Security Act of 1974 ("ERISA"), you have the right to bring legal action under Section 502 (a) of ERISA within three (3) years after you have exhausted your employer's plan's internal and external (if applicable) appeal process.

For questions about your appeal rights or for assistance, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

You have the right to appeal this decision directly using our External Review Program. It provides an independent review of your appeal by an external organization that's not connected to us.

The independent organizations are known as Independent Review Organizations or an IRO. The IROs we use for this program are separate companies, not connected to us professionally or financially. The decisions made by the IROs are binding, meaning we must accept it.

There's no charge to you for this program. **To be eligible to use the IRO appeal program, you must request a review within four (4) months of the date of this letter.**

Once the review is complete, you'll receive a letter with the decision. If you want to appeal through this external review program, the Customer must complete and sign the attached Request for IRO Review and Release Form and send it to the address below. The form has been sent to the Customer for their signature.

Cigna National Appeals Organization (NAO)
Attn: External Appeal Processing Unit
PO Box 188011
Chattanooga, TN 37422
Fax: (866) 380-5278

To get additional information about how the IROs are selected or about their relationship to us, call us using the number on the back of your ID card.

Additional Information related to the Affordable Care Act
If you're not satisfied with the final internal review, you may be able to ask for an independent, external review of our decision, as determined by your plan and any state or federal requirements.

Your state may also offer a consumer assistance or an ombudsman program to help you. Go online to mycigna.com, click on the Legal Disclaimer link at the bottom of the page, and select "State Ombudsman/Consumer Assistance Programs" from the drop

down menu. If you have difficulty accessing the website, call Customer Service at the toll-free number listed on the back of your ID card.

Please note that these program offices may not be the offices designated to receive your request for an external review. See the external review information above if applicable.

Language Assistance

If you have difficulty reading English, we offer language assistance. For help please call the Customer Service number on your ID card.

Si tiene problemas para leer el texto en inglés, le ofrecemos asistencia de idiomas. Para obtener ayuda, por favor, llame al número de Servicio al cliente que figura en su tarjeta de identificación.

Si vous avez des difficultés à lire l'anglais, nous offrons une assistance linguistique. Pour toute aide, veuillez composer le numéro du Service à la clientèle qui se trouve sur votre carte d'identification.

Für den Fall, dass Sie den englischen Text nicht verstehen, bieten wir mehrsprachige Unterstützung an. Rufen Sie in diesem Fall bitte die auf Ihrer Versicherungskarte angegebene Kundenservice-Nummer an.

Kung nahihirapan ka sa pagbabasa ng wikang Ingles, nag-aalok kami ng tulong sa wika. Para sa tulong pakitawagan ang numero ng Serbisyo ng Customer sa iyong ID card.

如果對您來說閱讀英文會有困難，我們可以提供您語言協助。欲取得協助，請撥打會員卡上的客戶服務電話號碼。

Bilagáana Bizaad wólta' nił naníl'ahgo, saad bee níká'a'doowołígíí hóló. Áká'a'áyeed biniiyé t'áá shǫǫdi áká'anídaalwo'go dabinaanishígíí bich'į' hodíílnih éí naaltsoos bee nee hózinigíí bikáa'gi bibéésh bee hane'é yisdzoh.

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on your ID card (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en su tarjeta de identificación (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số trên thẻ Hội viên của quý vị (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 귀하의 ID 카드에 있는 전화번호로 연락해주십시오(TTY: 다이얼 711).

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa iyong ID card (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана (TTY: 711).

Arabic – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم.لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué sur votre carte d'identité (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no seu cartão de identificação (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na karcie identyfikacyjnej (TTY: wybierz 711).

Japanese – 注意事項: 無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカードの電話番号 (TTY: 711) まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero riportato sulla tessera di identificazione (Utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf Ihrer Krankenversicherungskarte an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna، لطفاً با شماره قید شده بر روی کارت شناسایی خود تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره گیری کنید).

Request for IRO (Independent Review Organization) Review and Release Form

Cigna

Patient Name: _____ **ID#:** _____

Patient Date of Birth: _____ **SR# from Prior Appeal Denial:** _____

Subscriber Name (if different): _____ **Relationship to Patient:** _____

Subscriber's Phone Number : _____

Subscriber's Employer Name: _____

Coverage determination that I am appealing: _____

I am attaching additional information for this appeal: ☐ **Yes** ☐ **No**

Please complete this section if you are authorizing someone else to act on your behalf

I am authorizing _____(name of individual) to act on my behalf in requesting a review in accordance with Cigna's External Review Program regarding the non-coverage determination dated _____. This authorization allows Cigna to disclose any individually identifying information to my representative. This includes releasing the results of the IRO decision to the above mentioned authorized representative.

Authorized Representative's Address: _____

Relationship to member: _____

I understand that the IRO will receive and review the following information from Cigna, its Agents or subsidiaries:

- My medical records and other documents that were reviewed during the internal review process.
- Documents from the internal review process, including a statement of the criteria and clinical reasons for the initial coverage decision.
- The contract document for my health care benefit plan (the description of my coverage).
- Any additional information not presented during the internal review process related to the appeal.

I understand that I may submit additional information related to this appeal **WITH THIS FORM** to be considered in the external review process. I understand that the decision of the IRO's reviewer(s) will be binding on Cigna and on me, except to the extent that there are other remedies available under State or Federal law. I understand that my appeal to an IRO cannot begin until I have submitted all required information. I understand I must provide the information requested below and if applicable, sign the release of records form which allows Cigna to forward certain information to the IRO. I understand that any forms returned to Cigna incomplete will be returned to me for completion and my appeal will not be forwarded to the IRO until I complete the form and provide all requested information.

I have read and understand the above information.

Signature of patient electing appeal: _____ **Date:** _____

If patient is unable to give consent because of physical condition or age, complete the following:

Patient is a minor _____Years of age or is unable to give consent, because _____

Signature of Parent/Guardian/POA: _____ **Date:** _____

Relationship: _____

Return Completed Form To: **Cigna Healthcare, Attn: External Appeal Processing Unit, P.O. Box 188011, Chattanooga, TN 37422, Fax #: (877) 815-4827**

SPECIAL AUTHORIZATION FORM FOR RELEASE OF RECORDS

FOR MENTAL HEALTH/REHABILITATION, ALCOHOL OR DRUG ABUSE AND OR DEPENDENCY, HIV ANTIBODY TEST RESULT AND/OR AIDS DIAGNOSIS AND TREATMENT

Cigna

This form should only be completed if you are releasing records related to Mental Health, Alcohol or Drug Abuse or HIV Diagnosis and treatment. You do not need to complete or return this form otherwise.

Patient Name: _____ **ID#:** _____

Patient Date of Birth: _____

Subscriber Name (if different): _____ **Relationship to Patient:** _____

Subscriber's Employer Name: _____

Subscriber's ID#: _____

SPECIAL AUTHORIZATION FOR RELEASE OF RECORDS FOR MENTAL HEALTH/REHABILITATION, ALCOHOL OR DRUG ABUSE AND OR DEPENDENCY, HIV ANTIBODY TEST RESULT AND/OR AIDS DIAGNOSIS AND TREATMENT.

Please initial all that apply:

_____ Include information related to diagnosis and/or treatment for alcoholism and/or drug abuse or dependency.

_____ Include information related to diagnosis and/or treatment for mental health/rehabilitation.

_____ Include information related to HIV antibody testing results and/or AIDS diagnosis and treatment.

I, _____ (Print name of member electing appeal) have elected to participate in Cigna's External Review Program and hereby authorize Cigna to release any and all relevant information identified herein to the Independent Review Organization that will review my appeal. Only information relevant to my appeal will be forwarded.

I hereby release Cigna, its Agents and Subsidiaries from any and all liability for fulfilling the authorization request for release of medical information to the Independent Review Organization. I understand that this consent is revocable by me, in writing, at any time except to the extent that action has been taken in reliance on it. I also understand that this consent will expire either ninety (90) days after the date of this signature or automatically when the record/information requested on this form has been provided to the requestor.

Signature of patient electing appeal: _____ **Date:** _____

If patient is unable to give consent because of physical condition or age, complete the following:

Patient is a minor _____Years of age or is unable to give consent, because _____

Signature of Parent/Guardian/POA: _____ **Date:** _____

Relationship: _____

Signature of Witness: _____ **Date:** _____

PROHIBITION OF REDISCLOSURE: Any further disclosure of the confidential information identified herein is prohibited by law.

Return Completed Form To: **Cigna Healthcare, Attn: External Appeal Processing Unit, P.O. Box 188011, Chattanooga, TN 37422, Fax #: (877) 815-4827**

000091

Cigna
PO Box 3050
Easton, PA 18043

GARY L. WAGONER, DC
16356 N. THOMPSON PEAK PKWY., #1089
SCOTTSDALE AZ 85260-2103

Cigna
Appeals
PO Box 188011
Chattanooga, TN 37422

Cigna.

November 17, 2021

Caitlin Walls
5609 W Desperado Way
Phoenix AZ 85083-7324

RE: Cigna Health Management, Inc. on behalf of Your Employer Plan

Name: Caitlin Walls
ID #: U09892130
Provider: Gary Wagoner, DC
Dates of Service: 12/11/2018
SR #: 1329937499

13950000402

Dear Caitlin,

What Happens Next
We consider your request a "second level appeal". This review will consist of an Appeals Committee which will include a physician that wasn't involved in the original review. They're looking at your request as unbiased reviewers. The meeting details are:

Date: December 8, 2021
Time: 10:40 a.m. EST.

If you'd like to join by conference call, please let us know by 5:00 p.m. EST December 2, 2021 at (704) 752-5242 or via email @ L2CAR@Cigna.com. Please provide your name and phone number, the names and phone numbers of any other person(s) who will be joining with you or on your behalf and the service request number (SR#) noted above in the "RE" section. If we don't hear from you by this date, you'll give up your chance to take part in the Appeals Committee meeting.

This meeting is not a formal legal proceeding. I'll present your issue to the Appeals Committee. If you join this meeting, you'll have a chance to explain your issue to

the Appeals Committee members and they may ask you questions. The Appeals Committee will make a decision based on the original information in your file, the information submitted with this request and any information presented during the meeting.

Then, within thirty (30) calendar days from October 26, 2021, we'll send you a letter with the Appeals Committee's updated coverage decision. We'll also let you know in writing if we need more time to gather information.

Please send me any additional information you think should be considered as part of this Appeals Committee review. I need this information at least three (3) calendar days prior to the committee. This allows the committee members a chance to conduct a full and fair review of your appeal prior to the Committee meeting. Any written information received the day of the committee may not be considered as there may not be an opportunity to distribute the material to the Committee. You may send the information to:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422
Fax: (866) 380-5278

Questions
If you have any questions, please call our Customer Service Department at the toll-free number listed on your ID card. We'll be happy to help you.

Sincerely,

Yolanda T.
Appeals Processor

Enclosures: Non-Discrimination and Language Assistance Notice

c: Gary L. Wagoner, DC

Cigna
PO Box 3050
Easton, PA 18043

GARY L. WAGONER, DC
16356 N. THOMPSON PEAK PKWY., #1089
SCOTTSDALE AZ 85260-2103

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on your ID card (TTY: Dial 711).

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Cigna
Appeals
PO Box 188011
Chattanooga, TN 37422

Cigna.

October 5, 2021

Caitlin Walls
5609 W Desperado Way
Phoenix AZ 85083-7324

RE: Cigna Health Management, Inc. on behalf of Your Employer Plan

Name: Caitlin Walls
ID #: U09892130
Provider: Gary L Wagoner DC
Dates of Service: 12/11/2018
SR #: 1321814586

Dear Caitlin,

What Happens Next
We consider your request a "second level appeal". This review will consist of an Appeals Committee which will include a physician that wasn't involved in the original review. They're looking at your request as unbiased reviewers. The meeting details are:

Date: October 13, 2021
Time: 11:50 a.m. EST.

If you'd like to join by conference call, please let us know by 5:00 p.m. EST October 11, 2021 at (704) 752-5242 or via email @ L2CAR@Cigna.com. Please provide your name and phone number, the names and phone numbers of any other person(s) who will be joining with you or on your behalf and the service request number (SR#) noted above in the "RE" section. If we don't hear from you by this date, you'll give up your chance to take part in the Appeals Committee meeting.

This meeting is not a formal legal proceeding. I'll present your issue to the Appeals Committee. If you join this meeting, you'll have a chance to explain your issue to

the Appeals Committee members and they may ask you questions. The Appeals Committee will make a decision based on the original information in your file, the information submitted with this request and any information presented during the meeting.

Then, within thirty (30) calendar days from September 14, 2021, we'll send you a letter with the Appeals Committee's updated coverage decision. We'll also let you know in writing if we need more time to gather information.

Please send me any additional information you think should be considered as part of this Appeals Committee review. I need this information at least three (3) calendar days prior to the committee. This allows the committee members a chance to conduct a full and fair review of your appeal prior to the Committee meeting. Any written information received the day of the committee may not be considered as there may not be an opportunity to distribute the material to the Committee. You may send the information to:

Cigna National Appeals Organization (NAO)
Attn: Appeals
PO Box 188011
Chattanooga, TN 37422
Fax: (866) 380-5278

Questions
If you have any questions, please call our Customer Service Department at the toll-free number listed on your ID card. We'll be happy to help you.

Sincerely,

Yolanda T.
Appeals Processor

Enclosures: Non-Discrimination and Language Assistance Notice

c: Dr. Gary L. Wagoner

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on your ID card (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en su tarjeta de identificación (los usuarios de TTY deben llamar al 711).

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Summary of Benefit Plans

January 1, 2018

PINNACLE WEST
CAPITAL CORPORATION

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits
Description of how Benefits are paid for Covered Health Services provided by Network provider.

Non-Network Benefits
Description of how Benefits are paid for Covered Health Services provided by Non-Network providers.

Non-Preferred Brand Drug
Brand name medication that is not on a provider's approved formulary.

Open Enrollment
Period of time, determined by Pinnacle West, during which eligible Employees may enroll themselves and their Dependents under the Plan. Generally, during October or November, with enrollment changes taking effect on January 1.

Out-of-Pocket Maximum
Maximum amount you pay every calendar year. Prescription drug costs count towards the medical plan Out-of-Pocket Maximum along with all Copays, Coinsurance, Deductibles and similar payments. Dispense as written penalties and charges in excess of Usual and Customary (U&C) fees for Non-Network benefits do not count towards the Out-of-Pocket Maximum.

Partial Hospitalization/Day Treatment
Structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Products
FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician
Any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law. Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Physician Assistant
A person who is licensed to perform health care tasks pursuant to a dependent relationship with a physician and operates within the scope of the tasks approved by the supervising physician and medical board.

Plan Administrator
Pinnacle West Capital Corporation or its designee as that term is defined under ERISA.

Preferred Brand Drug
Preferred brand-name medication that may or may not have a generic equivalent and is included on a provider's formulary. These drugs are chosen by a team of doctors and pharmacists due to their clinical superiority, safety, ease of use and cost.

Pregnancy
Includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

Premium
Dollar amount that the employee pays per pay period for medical, dental, vision or life insurance; medical, dental and vision premiums are pre-tax dollars.

Primary Care Physician (PCP)
Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician.

Private Duty Nursing
Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true: no skilled services are identified; skilled nursing resources are available in the facility; the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure
Procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result

Other Important Information

Your Relationship with the Claims Administrators and Pinnacle West

In order to make choices about your health care coverage and treatment, Pinnacle West believes that it is important for you to understand how the Claims Administrators interact with the Pinnacle West Benefit plans and how it may affect you. The Claims Administrators helps administer the benefit plans in which you are enrolled. The Claims Administrators do not provide medical/dental services or make treatment decisions. This means:

- Pinnacle West and the Claims Administrators do not decide what care you need or will receive. You and your Provider make those decisions.
- The Claims Administrators communicate to you decisions about whether the Plan will cover or pay for the care that you may receive (the Plan pays for Covered Services, which are more fully described in this SPD).
- The Plan may not pay for all treatments you or your Provider may believe are necessary. If the Plan does not pay, you will be responsible for the cost.
- Pinnacle West and the Claims Administrators may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Pinnacle West and the Claims Administrators will use individually identifiable information about you as permitted or required by law, including in operations and in research. Pinnacle West and the Claims Administrators will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Pinnacle West, the Claims Administrators and Network providers are solely contractual relationships between independent contractors. Network providers are not Pinnacle West's agents or employees, nor are they agents or employees of the Claims Administrators. Pinnacle West and any of its employees are not agents or employees of Network providers. Likewise, the Claims Administrators and any of its employees are not agents or employees of Network providers.

Pinnacle West and the Claims Administrators do not provide health care services or supplies, nor do they practice medicine. Instead, Pinnacle West and the Claims Administrators arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrators' credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Pinnacle West's employees nor are they employees of the Claims Administrators. Pinnacle West and the Claims Administrators do not have any other relationship with Network providers such as principal-agent or joint venture. Pinnacle West and the Claims Administrators are not liable for any act or omission of any provider. The Claims Administrators is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Pinnacle West is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

Pinnacle West and the Claims Administrators have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Pinnacle West and the Claims Administrators may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Pinnacle West may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Pinnacle West does so in any particular case shall not in any way be deemed to require Pinnacle West to do so in other similar cases.

Information and Records

Pinnacle West and the Claims Administrators may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Pinnacle West and the Claims Administrators may request additional information from you to decide your claim for Benefits. Pinnacle West and the Claims Administrators will keep this information confidential.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Pinnacle West and the Claims

Administrators with all information or copies of records relating to the services provided to you. Pinnacle West and the Claims Administrators have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed an enrollment form. Pinnacle West and the Claims Administrators agree that such information and records will be considered confidential.

Pinnacle West and the Claims Administrators have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Pinnacle West is required to do by law or regulation. During and after the term of the Plan, Pinnacle West and the Claims Administrators and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes, as permitted by law.

For listings of your medical records or billing statements contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.
If you request medical forms or records from the Claims Administrators, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Pinnacle West and the Claims Administrators will designate other persons or entities to request records or information from you or information about you, and to release those records as necessary. The Claims Administrators' designees have the same rights to this information as does the Plan Administrator.

Plan and Administrative Facts

Below is required plan information about Pinnacle West benefits.

Plan Sponsor
Pinnacle West Capital Corporation
400 N. 5th Street
Phoenix, AZ 85004

Employer ID Number
86-0512431

Plan Administrator
The Benefit Administration Committee is the Plan Administrator for the following plans:

- The medical component of the Pinnacle West Capital Corporation Group Life and Medical Plan
- The PNW Dental Plan, Vision, Health Care Flexible Spending Account, and Dependent Care Flexible Spending Account components of the Pinnacle West Capital Corporation Group Welfare Plan

Benefit Administration Committee
Pinnacle West Capital Corporation
400 N. 5th Street, MS 8467
Phoenix, AZ 85004
(602) 250-3500

For the life and AD&D components of the Pinnacle West Capital Corporation Group Life and Medical Plan, the Plan Administrator is:

Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, PA 19192-2235

For the EDS Plan component of the Pinnacle West Capital Corporation Group Welfare Plan, the Plan Administrator is:

Employers Dental Services
3430 East Sunrise Drive, Suite 160
Tucson, AZ 85718
(800) 722-9772